Appeal Games Providers Play: Stick to the Rules for the Win

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Health benefits appeals by providers can be intimidating for a plan. The rules are detailed and especially if the provider is represented by a lawyer the demands can be pretty threatening. In my experience this is all too often aggravated by providers who don't play by the rules themselves and try to game the appeals process.

Appeals of dialysis claims may be one of the most common. There are probably two reasons for this: First, a beneficiary on dialysis typically needs three treatments per week, each of which generates a claim, under plan coverage over a sustained period of time; and second, because of the extreme concentration of the outpatient dialysis market (two very large dialysis chains control two-thirds or more of the market), dialysis rates charged to self-insured plans in particular are greatly inflated. Plans need to control dialysis costs, but when they take steps to control them, providers appeal. Working in this area I've reviewed several hundred appeals over more years than I care to remember and seen some pretty creative tricks.

The solution in all cases, however, is to recognize that playing by the rules in fact protects the plan and insisting that providers do the same defeats their

games. With that goal in mind, here are some of the tricks I've seen tried and the strategies to deal with them.

Is This an Appeal, or Isn't It?

Not every letter, fax or phone call about a claim counts as an appeal. Providers do sometimes have legitimate questions and there can be claims payment errors which can and should be cleared up without need for an appeal. The US Department of Labor (DOL) recognizes this and lets plans distinguish between claims queries and appeals. When you get a legitimate query, it should get the appropriate answer.

What is less legitimate and more confusing, are letters and calls that demand payment and maybe threaten legal consequences, without identifying themselves as appeals. The game in this case is to try to persuade the plan to pay more without bothering with actually appealing. This is sometimes tried when it's very clear any appeal would be denied, for example because it is too late. A plan which lets itself be intimidated this way winds up paying more than it should, sometimes much more.

The solution is to insist that any appeal be filed as required by ERISA and the plan documents. Plan appeal processes can and should and in the vast majority of cases do, require appeals to be in writing directed to a specific address or office and to include specific information. No demand which fails to meet these requirements should be accepted as an appeal. Any communication to the claimant in response to such a demand should include a statement that it was not accepted as an appeal.

Guess My Authority!

The right to appeal claims decisions lies with the beneficiary who received the health care, or if the beneficiary is not competent (e.g. a minor or not capable of making decisions for him or herself), the beneficiary's legal representative. The beneficiary's health care provider does not have its own right to appeal claims decisions, though sometimes some seem not to understand that.

A beneficiary can and typically will, assign the provider the right to file claims and receive payments directly. However, this kind of assignment of benefits is not enough to authorize the provider to pursue appeals with the plan. This is a separate authorization to act as the beneficiary's "authorized representative," though it can be included in the same document as the assignment of benefits. Most providers' forms include this kind of authorization, but some do not. In addition, some plans prohibit assignment of benefits, though most do not in order to minimize inconvenience to beneficiaries.

A provider's unsupported assertion of a right to appeal therefore should not be accepted and the provider should be required to provide a copy of the assignment and authorization, signed by the beneficiary. This document should be reviewed and if there is any question the plan documents should be checked, to confirm the provider has valid authority to exercise the beneficiary's right to appeal.

Bringing Untimely Claims Back from the Dead

ERISA is clear: A plan has to allow a beneficiary at least 180 days to file an appeal from the date of an adverse benefit notification on a claim and doesn't have to accept appeals which are not timely filed. A plan can allow for more time than that, but every plan document I've ever seen allows 180 days. This applies to both first-level appeals and second-level appeals if the plan allows for them.

Some appeals ignore this rule and try to include adverse benefit notifications given well over 180 days before. The provider really has nothing to lose by trying this; if the plan makes the mistake of accepting and responding to an untimely appeal, it may have waived the right to reject it as untimely. A plan might therefore accidentally revive an appeal which was dead on arrival.

Untimely appeals are easy enough to detect when there is only one or are only a few claims and all were clearly determined more than 180 days ago. In those cases, the easy solution is to reject the appeal as not timely.

It's more difficult where the provider throws together a big batch of appeals of a variety of adverse benefit determinations, some of which are timely and some of which are not. Where it looks like this is being tried the claims and any previous appeal records should be carefully reviewed. If any appeals are found to be untimely, they should be rejected separately from the substantive response the plan makes to any timely appeals. If the plan mistakenly responds to all the appeals substantively, it may revive the untimely appeals as well.

Somebody Said Something, Sometime

One of the more common appeal games is the claim that the plan somehow communicated to the provider that it would be paid at a specific rate and that the provider relied on that representation in accepting the beneficiary as a patient. If in fact this happened and the plan (or someone with authority acting on its behalf) did clearly and unconditionally make such a representation, then the plan may very well be stuck with it.

This shouldn't happen and in fact doesn't happen often. What does happen is that someone acting on behalf of the provider may call the plan (or its administrator) to confirm coverage – or the provider will claim that happened, even if it didn't. If a call is made, the appropriate response is to confirm that the patient is a beneficiary of the plan, but that the terms of coverage are determined by the plan and not guaranteed.

To deal with this gamesmanship the plan, or administrator, should be very clear who is authorized to respond to providers making this kind of inquiry. Those responding to such inquiries should be trained not only in how to respond, but also in responses they should not make and are not authorized to make. There should be records of all such calls, with names of all parties, time and date and content of the call. It might also be helpful to have a standardized recording the caller has to listen to before being connected, which states these limitations.

In this game, the provider is trying to set the plan up to have to prove a negative – to prove that the call didn't happen. The solution is to make sure your records let you do just that.

Let's Throw It All at the Wall

One of the more irritating games I see is the inclusion of issues in an appeal which have little or nothing to do with the actual benefits determinations – just sort of throwing them at the wall and hoping something sticks. Sometimes it seems like this is just laziness – for example, when the appeal letter is clearly a cut-and-paste of an earlier letter to a different plan. (The inclusion of the other parties' name by accident can be a dead giveaway.) More often, it seems intended to make responding to the appeal more difficult and make the appeal seem more serious and threatening.

Unfortunately, if an issue is raised in an appeal, it does need a response and the response needs to address the merits. This sometimes means several paragraphs (or a few pages) discussing why an issue is actually not presented, or is irrelevant. Fortunately, there are only so many issues that even the most creative mind can develop, so once you've seen an issue a few times it's pretty straightforward to answer it.

Unfortunately, you still have the burden of making the response and if you haven't seen the issue before that can take some work. The good news is, however, that in the process you can and should be able to develop a solid appeal record that would clearly withstand judicial scrutiny.

Return of the Zombie Appeal

Plans are required to have at least one appeal level; most have two; and more than two levels of appeal is prohibited. Some providers may nonetheless try to appeal again after appeals have been exhausted.

This may be in the form of a specific appeal of the final appeal determination of a claim or claims, or the appeal may be thrown in as part of a batch of claims including some which are valid, as in the discussion of untimely appeals above. As with untimely appeals, a plan which responds to an exhausted appeal substantively risks bringing it back from the dead.

As with untimely appeals, then, any attempt to appeal an exhausted appeal should be rejected separately from any substantive response.

Play by the Rules for the Win

If a plan sticks to the ERISA rules and its plan language and insists providers do it too, at the end of the appeals process the provider's alternatives are to (1) accept the payments received, (2) seek external review, an option which is only available if the determinations involved a medical judgment and did not involve a contractual or legal interpretation, or involved a rescission of coverage, or (3) seek judicial review. A plan which takes the appeals process seriously and uses it to build a good record supporting its determinations should be in a good position to defend itself in court.

Judicial review of plan determinations under ERISA is very deferential to informed plan judgment. An ERISA action is decided by a judge without a jury, based on the record developed on the plan appeals. If the appeal determinations were based on a reasonable interpretation of the applicable plan language and appropriate information and weren't biased by a conflict of interest, the court is supposed to uphold the plan's determinations.

Given these standards, a plan which has made sure that the appeals record clearly shows the claims considered, the bases for their determination and the reasons for those determinations, will have made it clear that it should win if the provider takes it to court. Nobody wants to start litigation they expect to lose and in this kind of limited litigation the plan wouldn't even be threatened with uncontrolled legal fees. A provider in this situation has no incentive to try judicial review – and so a plan which makes sure its appeals are played by the rules should win the game. ■

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